ILLINOIS WORKERS' COMPENSATION COMMISSION

INJURED WORKERS' BENEFIT FUND:
REQUEST TO CERTIFY LACK OF INSURANCE COVERAGE

Attorneys: Complete this form only if you have searched the online database for employer's insurance coverage and have been unable to find coverage. Please **fax** this form and copies of any relevant information, e.g., W-2s, *Application of Adjustment of Claim,* and an employee's paycheck stub to the Insurance Compliance Division at 312/814-5979.

_____ Case # ____ WC _____
Employee/Petitioner

v.

_____
Employer/Respondent

Date(s) of injury _____

Location of injury _____

Employer's name _____

Owner(s)/Officer(s) _____

Employer's address(es) _____

Employer's FEIN(s) _____
(Federal Employer Identification Number)

If Temporary/PEO service, name and address of servicer _____

_____

If construction company, please include the site address _____

I certify that I have searched the NCCI online database for insurance for this case and did not find policy information for this employer.

_____ _____
Name Signature Date

_____
Your street address, city, state, zip code

Due to heavy demand, please allow a *minimum* of four weeks for a reply to this request for certification. Making multiple requests will only delay the requested information.